

based on a randomized trial directly comparing bicalutamide and flutamide. Costs and quality of life effects related to therapy were based on published sources. Cost-effectiveness was calculated for 60 and 120 months from start of therapy. **RESULTS:** The incremental cost per quality adjusted life year (QALY) gained for bicalutamide vs. flutamide was \$22,000 and \$16,000 per QALY at five and ten years, respectively. If quality adjustment was not included, the incremental cost-effectiveness ratio (ICER) for CAB with bicalutamide over CAB with flutamide was even more favorable (\$20,000/LY gained at five years). These ICER estimates are well within the commonly accepted cost-effectiveness threshold. One way sensitivity analysis demonstrated that the cost-effectiveness estimates were most sensitive to drug costs and survival (baseline survival was not significantly different between therapies). Multi-way uncertainty analysis revealed that the median value of the ICER at five years was \$13,637/QALY when all the parameters were varied over a clinically reasonable range. **CONCLUSIONS:** Bicalutamide is cost-effective compared with flutamide when used for androgen blockade as part of combined androgen blockade for men with advanced prostate cancer.

## PCN15

#### RESOURCE UTILIZATION AMONG PROSTATE CANCER PATIENTS WITH BONE PAIN

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**OBJECTIVES:** Bone metastases occur in up to 80% of advanced prostate cancer patients, and could result in painful and debilitating skeletal complications. The objective of this study was to evaluate resource utilization in advanced prostate cancer patients *with* versus *without* bone pain. **METHODS:** A multi-center retrospective chart review combined with prospective quality of life and pain assessment study was initiated to collect data from approximately 375 patients from 73 US community urology practices. Patients were categorized as either *with* or *without* bone pain. Interim analysis compared resource utilization (hospitalizations, physicians visits) between the two groups, using t-tests and Chi-square tests ( $p < 0.05$ ) to assess differences. **RESULTS:** Of 277 patients recruited to date, mean age was 76 years, and majority (74%) were Caucasian. About 39% ( $N = 109$ ) had bone pain and the remaining 61% did not. Patients with bone pain were significantly younger than those without (75 vs. 77 years) and more likely to have bone metastases (62% vs. 40%). However, the groups did not differ significantly in ethnicity, education, or comorbid conditions. Patients with bone pain were over twice as likely to have been hospitalized in the past year (28% vs. 13%) than those without and averaged 1.3 hospitalizations per patient and 4.2 days per stay. While outpatient visit rates were similar, patients with bone pain were less likely to make routine physician visits (42% versus 61%), instead seeking treatment for non-routine reasons (e.g. LH-RH agonist administration, initial/post-op consults, procedures/surgery). Patients with bone pain were more likely to visit for SRE (8% vs. 3%) and to receive a referral to oncology/urology (6% vs. 3%) at physician visits. **CONCLUSIONS:** Patients with bone pain have increased health resource consumption, particularly hospitalizations, than patients without bone pain, which may result in substantial economic burden.

## PCN16

#### THE CLINICAL OUTCOMES AND COSTS OF TREATING ONCOLOGY PATIENTS FOR SEVERE SEPSIS

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**OBJECTIVE:** Sepsis is a systemic inflammatory syndrome in response to infection. Sepsis is considered severe when associated with organ dysfunction, hypoperfusion, or hypotension. Severe sepsis is considered the most common cause of death in non-coronary critical care units. The impact of severe sepsis on the oncology population has not been fully delineated. The objective of this observational study is to describe the clinical outcomes and direct medical costs of treating severe sepsis in the oncology population at a comprehensive cancer center. **METHODS:** A convenience sample of 20 intensive care unit patients diagnosed with severe sepsis was followed prospectively during their severe septic episode until death or hospital discharge. Clinical information was obtained from the patient medical record. Resource utilization and costs were retrieved from the institution's financial database. **RESULTS:** The sample was 60% male with a mean age of 63 years (27–82). The medical/surgical mix of patients was 50/50. Sixty percent of patients had solid tumors and 40% had hematological malignancies. Four patients were neutropenic on ICU admission. Eighty percent of patients had an APACHE II score  $\geq 25$  on admission to the ICU. The majority of patients required vasopressor support (95%) and mechanical ventilation (85%). Eight patients (40%) required dialysis and seven patients (35%) received drotrecogin alfa. The lung was the most common presumed infection source. The mean length of stay in the ICU was 16 days (1–41). Survivors constituted 25% of the group. The top cost drivers for physician services included: 1) intensive care unit; 2) nephrology; and 3) radiology and for hospital care included: 1) room and board; 2) pharmacy; and 3) respiratory care. A detailed cost analysis is ongoing. **CONCLUSION:** The clinical outcomes of oncology patients who develop severe sepsis are poor despite intensive therapeutic intervention and resultant high resource utilization and costs.

## PCN17

#### ASSESSMENT OF BREAST CANCER KNOWLEDGE, SCREENING BEHAVIOR, RISK PERCEPTIONS, AND WILLINGNESS TO CONSUME CHEMOPREVENTIVE AGENT IN WOMEN IN THE WEST VIRGINIA MEDICAID PROGRAM (WVMP)

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**OBJECTIVE:** To determine breast cancer knowledge, screening behavior, perceived risk, and willingness to consume chemopreventive agent and their interrelationships in West Virginia Medicaid Program (WVMP) women enrollees. **METHODS:** A survey of randomly selected women  $>40$  years of age who were enrollees of WVMP was conducted. The questionnaire collected information on following components: utilization of breast cancer preventive strategies, perceived and actual (as calculated by Gail model) risk of breast cancer, breast cancer knowledge, and willingness to consume chemopreventive agents. **RESULTS:** A total of 606 responses were obtained from a reachable sample size of 1502, yielding a response rate of 40.4%. Non-response bias assessment indicated minimal potential for non-response bias. Only 50.7% of respondents were compliant with the American Cancer Society screening guidelines. Almost none of the respondent (96.7%) had ever taken chemopreventive tamoxifen. A large proportion of respondents were not sure about their